X2017 - 5 PRINTED: 01/30/2017 FORM APPROVED

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		504009		B. WING _		-01/20	/2017	
NAME OF F	PROVIDER OR SUPPLIER		2600 SOUT	DDRESS, CITY, STATE, ZIP CODE BUTHWEST HOLDEN E, WA 98126				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I BC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
L 000	INITIAL COMMENT	S		L 000				
	Navos Psychlatric I- 1/20/2017 by Tyler I Cathy Strauss BSN ASE #HZP911	nsing survey was cor lospital on 1/18/2017 Henning ScM, MHS;	to		1. A written PLAN OF CORRECT required for each deficiency lister Statement of Deficiencies. 2. EACH plan of correction stater must include the following: The regulation number and/or the number; HOW the deficiency will be coverection; WHAT will be done to prevent reoccurrence and how you will monitor for conficompliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION be returned within 10 business days from the date you the Statement of Deficiencies. Your Plans of Correction must be postmarked by 2-15-2017 4. Return the ORIGINAL REPORT the required signatures.	ment e tag corrected; ing the nt tinued		
L 350	322-035.1J POLICI	ES-INFECTION CON	ITROL I	∟350 .				
		e licensee shall nent the following procedures chapter and j) Infection						

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

COS) DATE

STATE FORM

B21199

HZP91

If continuation sheet 1 of 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)			ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY - LETED
İ		504009	• •	B. WING	G		0/2017
NAME OF P	PROVIDER OR SUPPLIER		2600 SQU	DRESS, CITY, S THWEST H WA 98126			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	(X5) COMPLETE DATE	
L 350	Continued From Pa	age 1		L 350			-
	policies and proced	ion, interview and rev lures, the hospital fai equipment was clea	led to				·
		lent care equipment een patients and sta			,		
	Findings:						
	observed the medic take a blood pressu medication to Patie	8:00 AM, Surveyor # cation nurse (Staff More) and deliver a nt #1, then return the chine to the nurses a after use.	ember #1) a portable		·		
	interviewed with the Member #2) about to cleaning and sanitize	9:00 AM, Surveyor # Nurse Manager, (Si the hospital's policy f ting of the BP cuff an atients. The Nurse N e a policy.	taff or id				
	Officer/ Infection Co	11:00 AM, the Chief ontrol Professional, (a ned the above finding	Staff				
L 420	322-040.1 ADMIN-A	ADOPT POLICIES	}	L 420			
·	Administration. The shall: (1) Adopt write concerning the purp maintenance of the safety, care and trepatients;	tten policies poses, operation and hospital, and the					
						-	

HZP911 If continuation sheet 2 of 27 021199 STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l	(X2) MULTIPLE CONSTRUCTION A. RUILDING		SURVEY LETED
J		504009		B. WING		01/2	0/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY.	STATE, ZIP CODE		
NAVOS				JTHWEST H , WA 98126			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 420	Continued From Page 2.			L 420			
	Based on observation, interview and review of policies and procedures the hospital failed to ensure the patient comfort rooms were safe and free from risks of harm in 2 of 2 comfort rooms.						
		atient areas are safe for death and harm to		' . 			
	Findings:		ļ				
	the 3rd floor patient (Staff Member #2). mounted on the wal	10:30 AM, Surveyor areas with the Char There was a televis Il in the "Comfort Ro ne of the visible cable	ge Nurse, sion om" with	,			
-	2. The Charge Nurse stated that the hospital did not have a policy regarding looking at patient areas for specific safety issues, but that the facilities staff did a "monthly walk through". Review of the last 2 months of the monthly "walk through" by the facilities staff indicated that floor 2 and floor 3 were "OK". The specific "comfort room" was not identified on the form. 3. The Chief Nursing Officer reported that the clinical staff do monitoring of all patients every 15 minutes and that the Administrative staff do a monthly "Infection Control Rounding Log", which included infection control observation as well as environmental and equipment checks. Logs were reviewed for the last 2 months without notations of ligature risks or other safety issues.						
L 545	322-050.6A ORIENTATION-ORG			L 545			
	WAC 246-322-050 shall: (6) Provide ar orientation and app	nd document		:			
If deficiencies	s are cited, an approved p	plan of correction is requi	site to continu	ed program p	articipation.		

STATE FORM

021199

HZP911

If continuation sheet 3 of 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	PLE CONSTRUCTION	(X3) DATE S COMPL		
		504009		B. WING 01/20/2			0/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	FADDRESS, CITY, STATE, ZIP CODE				
NAVOS				PUTHWEST HOLDEN E, WA 98126				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TÉMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
L 545	Continued From Pa	ge 3		L 545				
	for all staff, including: (a) Organization of the hospital; This RULE: is not met as evidenced by: Based on document review and interview, the hospital failed to ensure that contracted staff were oriented to the organization of the hospital.						-	
	Fallure to orient contracted staff to the organization of the hospital places patients at risk for inadequate care.							
;	Reference: Washington Administrative Code 246-324-010 (43), " 'Staff' means permanent employees, temporary employees, volunteers, and contractors."							
	Findings:							
	1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding the organization of the hospital.							
	2. During the review, the human resources assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains these staff members' human resources files. No files for these employees were kept on site at the hospital.							
L 550	322-050.6B ORIEN	TATION-PHYSICAL	LAYOUT	L 550				
	WAC 246-322-050 shall: (6) Provide a	Staff. The licensee and document			÷			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

If continuation sheet 4 of 27 HZP911 STATE FORM 021100

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY ETED
		. 504009 B. WING			01/20/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		-
NAVOS			-2600 SOUT SEATTLE,		OLDEN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE. MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
L 550	orientation and app for all staff, includin layout of hospital, in buildings, department services; This RULE: is not reservices; This Rule: is not reservice	ropriate training g: (b) Physical acluding ents, exits, and met as evidenced by t review and interview are that contracted sical layout of the host tracted staff to the pal places patients at a places patients at a system of the part	w, the staff were spital. hysical risk for Code nanent nteers, and 12:00 PM, of the 6 per (Staff on of arding the ces contracted same al. S/he maintains of the s. No	L 550	DEFICIENCY		
	, ,						

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			1''	PLE CONSTRUCTION	(X3) DATE S COMPL			
		504009		B. WING_		01/20	0/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE			
NAVOS				THWEST H WA 98126				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
L 555	Continued From Pa	ge 5		L 555				
L 555	322-050.6C TRAIN	ING-DISASTER PLA	NS	· L. 555				
	Based on document hospital falled to encoriented on the fire a hospital. Failure to orient condisaster plan of the	nd document ropriate training g: (c) Fire and	w, the staff were the ire and ents and				·	
	246-324-010 (43), employees, tempora contractors."	gton Administrative C 'Staff' means pern ary employees, volur	nanent	;				
	Findings:							
	Surveyor #1 reviewed documents for six s staff members, a commember #4), did no	tween 9:09 AM and 1 and human resources taff members. One contracted housekeep t have documentatio ropriate training on the	of the 6 er (Staff n of		-			
	assistant (Staff Men staff are not oriented manner as staff em- also stated that the these staff member	y, the human resource mber #5) stated that of d and trained in the s ployed by the hospita contracted company s' human resources byees were kept on s	contracted same al. S/he maintains files. No					

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1. 1	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		504009		B. WING 01/20/20			0/2017
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
NAVOS			2600 SOUT SEATTLE,				ļ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY 8C IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 555	Continued From Page 6			L 555			
	hospital.						
L 560	322-050.6D TRAIN	ING-INFECT CONTI	ROL	L 560	4		
	WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (d) Infection control; This RULE: is not met as evidenced by:				·-	,	
		t review and interview sure that contracted n control.					
		tracted staff on infect onts and staff at risk f				·	
	246-324-010 (43), i	gton Administrative (''Staff' means pem ary employees, volur	nanent	!			
	Findings:						
	Surveyor #1 reviewed documents for slx s staff members, a commember #4), did no	tween 9:09 AM and red human resources taff members. One contracted housekeep thave documentation regardate training regardate.	of the 6 er (Staff		,		
	assistant (Staff Mer staff are not oriente manner as staff em also stated that the	the human resource the	contracted same al. S/he maintains				

if deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATE FORM 021119 HZP911 If continuation sheet 7 of 27

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	PLE CONSTRUCTION G	(X3) DATE S	SURVEY ETED
		504009		B. WING		04/2	0/2017
NAME OF F	PROVIDER OR SUPPLIER	304003			STATE, ZIP CODE		0/2017
NAVOS	NOVIDER ON SUFFLIER		2600 SOUT SEATTLE,	HWEST H			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	(X5) COMPLETE DATE	
L 560	Continued From Page 7			L 560	,		
	files for these employees were kept on site at the hospital.						
L 565	322-050.6E ORIEN	TATION-DUTIES		L 565			
~	WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (e) Specific duties and responsibilities; This RULE: is not met as evidenced by:				· .		
•	Based on document hospital failed to ensoriented on specific	sure that contracted	staff were		·		
	Failure to orient con and responsibilities inadequate care.						
-	Reference: Washing 246-324-010 (43), " employees, tempora contractors."	''Staff' means pem	nanent		·		
.]	Findings:						
	On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding specific duties and responsibilities.						
	2. During the review assistant (Staff Men staff are not oriente manner as staff em also stated that the	nber #5) stated that d and trained in the ployed by the hospit	contracted same al. S/he				

If continuation sheet 8 of 27 STATE FORM 021199 HZP911

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION . IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED .		
		504009		B. WING_	V (7,507,50)		0/2017
NAME OF F	PROVIDER OR SUPPLIER		2600 SQU	RESS, CITY, THWEST H WA 98126	STATE, ZIP CODE OLDEN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
L 565	Continued From Page 8			L 565			
	these staff members' human resources files. No files for these employees were kept on site at the hospital.					-	
L 570	322-050.6F ORIEN	TATION-P&P		L 570			
•	WAC 246-322-050 Shall: (6) Provide an orientation and apprior all staff, including Policies, procedures necessary to perform This RULE: is not	and document propriate training g: (f) s, and equipment m duties; net as evidenced by treview and interview are that contracted procedures, and equipment necessary that at risk for inadequipment Administrative (f) "Staff" means perr	w, the staff were uipment les, o perform uate care. Code nanent				
-	contractors." . Findings:			-			
	1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orlentation and appropriate training regarding policies, procedures, and equipment necessary to perform duties.						
	2. During the review	v, the human resour	ces .		·		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATE FORM

If continuation sheet 9 of 27 HZP911

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	PLE CONSTRUCTION	(X3) DATE S	
		504009		B. WING_			
NAME OF F	ROVIDER OR SUPPLIER			THWEST H	STATE, ZIP CODE OLDEN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE	
L 570	Continued From Pa	nge 9		L 570			
	staff are not oriente manner as staff em also stated that the these staff member	mber #5) stated that d and trained in the ployed by the hospit contracted company s' human resources byees were kept on s	same al. S/he maintains files. No				
L 575	322-050.6G ORIEN	TATION-PATIENT R	IGHTS	L 575			
	WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (g) Patient rights according to chapters 71.05 RCW and 71.34 RCW and patient abuse; This RULE: is not met as evidenced by: Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on patient rights and abuse. Failure to orient contracted staff on patient rights and abuse places patients at risk for inadequate care.						
	Reference: Washington Administrative Code 246-324-010 (43), "'Staff means permanent employees, temporary employees, volunteers, and contractors."					·	:
	Findings: 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding patient rights and abuse.						

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

If continuation sheet 10 of 27 STATE FORM HZP911

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CIJA IMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		504009				0/2017			
NAME OF F	PROVIDER OR SUPPLIER		2600 SOU	TREET ADDRESS, CITY, STATE, ZIP CODE 1600 SOUTHWEST HOLDEN SEATTLE, WA 98126					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
L 575	2. During the review assistant (Staff Mer staff are not oriente manner as staff em also stated that the these staff members files for these employes hospital. 322-050.6H ORIEN WAC 246-322-050 shall: (6) Provide an orientation and apprfor all staff, including patient behavior; This RULE: is not in Based on document hospital failed to ensoriented on managin Failure to orient compatient behavior platharm if disruptive be Reference: Washing 246-324-010 (43), employees, tempora contractors."	w, the human resourcember #5) stated that d and trained in the ployed by the hospit contracted companys' human resources byees were kept on staff. The licensee and document repriate training g: (h) Managing treview and interview and interview and interview and interview and patient behavior. It review and interview and patient behavior. It review and interview and patient behavior.	contracted same al. S/he y maintains files. No site at the EHAV EHAV Code manent nteers, and	L 580	DEFICIENC	**)			
	Surveyor #1 reviewed documents for six s staff members, a commember #4), did no	ed human resources	of the 6 per (Staff on of						

If continuation sheet 11 of 27 HZP911 STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S		
		504009		B. WING_	01/20/201		
NAME OF F	PROVIDER OR SUPPLIER		2600 SOU	RESS, CITY, 8 THWEST HO WA 98126	STATE, ZIP CODE OLDEN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL [ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE	
L 580	Continued From Pa	ige 11		L 580			
	assistant (Staff Mer staff are not oriente manner as staff em also stated that the these staff member	ehavior. y, the human resource mber #5) stated that d and trained in the se ployed by the hospite contracted company s' human resources byees were kept on s	contracted same al. S/he maintains files. No				
L 585	Based on documen hospital failed to en oriented with appropulaties. Failure to orient and expected duties plainadequate care. Reference: Washing 246-324-010 (43), employees, tempora contractors."	Staff. The licensee and document ropriate training g: (i)	w, the staff were pected off on or Code nament	L 585			
	Surveyor #1 review	tween 9:09 AM and ed human resources staff members. One o					

STATE FORM MITCH STATE FORM HZP911 If continuation sheet 12 of 27

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION .		(X3) DATE SURVEY COMPLETED	
		504009		B. WING 01/2			0/2017	
NAME OF F	PROVIDER OR SUPPLIER	,	ł	THWEST H	STATE, ZIP CODE OLDEN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
L 615	Member #4), did no orientation and app duties. 2. During the review assistant (Staff Mer staff are not oriente manner as staff em also stated that the these staff member files for these emple hospital. 322-050.9A TB-MAI WAC 246-322-050 shall: (9) In addition WISHA requirement from tuberculosis by staff person to have or starting service, a thereafter during the association with the tuberculin skin test method, unless the Documents a previous kin test, which is te millimeters of indurents.	ontracted housekeep thave documentation ropriate training for e y, the human resource the man resource the man resource the man resources to following the protect patients y requiring each to the man resource to following the man resources to foll	per (Staff per of per o	L 585	DEFICIENCY			
	this subsection with preceding the date (iii) Provides a writte the department or a health department s skin test presents a staff person's health	the requirements of in the six months of employment; or en waiver from the interior the Mantoux hazard to the						

If continuation sheet 13 of 27 HZP911 STATE FORM D21199

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ER/CLIA MBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		504009		B. WING	<u> </u>	01/20/2017		
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
NAVOS				THWEST HO WA 98126	OLDEN		• ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	(X5) COMPLETE DATE		
L 615	Continued From Pa	ge 13		L 615				
	Based on policy and review, and intervie that staff members testing for 1 of 6 states and the staff members place exposure to infection. The hospital policing in the states in part, "II. A will be required to his defined as any error shared space with need to have an and	d procedure review, w, the facility failed to received annual tube of members reviewed innual tuberculosis to patients and staff in. The worker (Rev. 4) If HCW (health care worker (Rev. 4) If HCW (health care ways an annual TB temployee who has any high patients. Non-HCV hual TB test."	o ensure erculosis d. esting for at risk of sis Testing (/2016)" workers) st. A HCW y contact V do not					
	Surveyor #1 reviewed documents for six signembers, an inform Member #7), did no tuberculin skin test recorded test was fired 3. On 1/19/2017 at a conducted an infect interview. The Chief Member #3) indicate staff perform mainterview.	m 9:09 AM to 12:00 ed human resources taff members. One hation technologist (\$\foatstyle{3}\) thave a documented within the last year. From 3/2014. 2:34 PM, Surveyors sion control committed in Nursing Officer (CN) ed that Information to enance work on paticave annual tuberculo	of the staff Staff d The last #1 and #2 se NO) (Staff echnology ent care			•		

STATE FORM 621999 HZP911 If continuation sheet 14 of 27

STATEMENT AND PLAN O	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		504009		B. WING _	WING 01/20/2)/2017	
NAME OF F	ROVIDER OR SUPPLIER		2600 SOU	RESS, CITY, S THWEST H WA 98126				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA .	FULL	ID . PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	(X5) COMPLETE DATE		
L 670	Continued From Pa	ge 14	7	L 670				
L 670	WAC 246-322-050 shall: (12) Maintain hospital premises for person, during empty years following term employment, includito: (g) Annual perforevaluations. This RULE: Is not not a superior of the person of the pers	a record on the or each staff loyment and for two nination of ing, but not limited rmance net as evidenced by treview, the hospital performance evaluatined for 1 of 6 staff in innual performance e facility 's ability to	failed to ions were nembers	L 670			·	
L 675	#1 reviewed human members. One staff technologist (Staff Mocumentation of all evaluation from the performance evaluation	f member, an inform Member #7) did not h n annual performand past year. The last ation on file was fron	staff ation nave ce	L 675		<i>.</i>	·	
		HIV/AIDS Education see shall: (1) propriate ing of staff within yment on the	and					

STATE FORM 621(99 HZP911 If continuation sheet 15 of 27

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		504009		B. WING 01/2			0/2017	
NAME OF PRO	VIDER OR SUPPLIER	·			STATE, ZIP CODE			
NAVOS			2600 SOUT SEATTLE,	THWEST H	OLDEN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL /	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	(XS) COMPLETE DATE		
L 675 C	ontinued From Pa	ge 15		L675		-		
vii in cc Ti Ba er re re Fa pla Oi Su do m	rus (HIV) and acquemunodeficiency sonsistent with RCV nis RULE: is not nessed on document asure that staff mequired HIV training viewed, allure to ensure that aces patients and andings: 1/19/2017 from surveyor #1 reviewed cuments for 6 stalents an inform	yndrome (AIDS)	I failed to Intation of Intain of Intation of Intation of Intain of In				-	
#8		cumented HIV traini						
L 715 32	22-100.1E INFECT	CONTROL-PROV	ISIONS	L 715		•		
The image in the i	AC 246-322-100 Ine licensee shall: (aplement an effect fection control procludes at a minimur; (i) Providing congarding patient caquipment and supplicence the risk of Providing consultation (appropriate procedur cleaning, (iii) Providing control information (appropriate)	(1) Establish and ive hospital-wide gram, which um: (f) Provisions asultation repractices, plies which may infection; tation regarding ures and products cting and ding infection	-					
		plan of correction is requi		- d n				

STATE FORM 621198 HZP911 If continuation sheet 16 of 27

STATEMENT AND PLAN O	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1'''	PLE CONSTRUCTION	(X3) DATE S	
		504009		B. WING_		01/2	0/2017
	PROVIDER OR SUPPLIER		1		STATE, ZIP CODE		•
NAVOS				THWEST H WA 98126	OLDEN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 715	Continued From Pa	ge 16		L 715			
	and in-service educe providing direct patin Making recommend with federal, state, a laws and rules, for rand sanitary disposs Sewage; (B) Solid a and (C) Infectious wasfe management of This RULE: is not rule and places on interview, that the infection conconsultation regardifor contracted environments and places risks inade and places patients. Findings: 1. On 1/19/2017 at 2 conducted an intervinfection control corcontrol practices in the Chief Nursing O #2) if the facility confidence with the facility with the	ation for staff ent care; (iv) lations, consistent and local methods of safe al of: (A) and liquid wastes; rastes including of sharps; net as evidenced by: the hospital failed to introl committee was ng procedures and p commental services. consultation regarding ducts for environmen quate housekeeping and staff at risk of ir 2:30 PM, surveyors a iew with members o inmittee regarding in the facility. Surveyor ifficer (CNO) (Staff M iducted observations	providing products I ntal practices fection. #1 and #2 f the fection r #1 asked Nember s or				
	staff to ensure that best practice and guthat the environment supervisor that observed in the stage of the st	tracted environments housekeeping functi- uidelines. The CNO stal services compan erves housekeeping seen performing dire	ons meet stated by has a staff, but				•
	2. During the meeting CNO if the infection and approved the c	ng, surveyor #1 aske control committee r leaning products tha used. S/he stated th	eviewed It the nat the				

STATE FORM HZP911 W continuation sheet 17 of 27

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			I ' '			(X3) DATE SURVEY COMPLETED	
	504009		B. WING _		01/2	0/2017	
PROVIDER OR SUPPLIER		l		•	•		
				OLDEN	<u> </u>	•	
(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TON SHOULD BE THE APPROPRIATE	(XS) COMPLETE DATE	
Continued From Pa	ge 17		715				
the committee did n	not perform a thoroug	gh review				-	
322-120.1 SAFE EN	NVIRONMENT	1	780				
WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: is not met as evidenced by:							
		to provide				•	
		aces		٠			
Findings:							
a tour of the facility. inspected the bathro outlet receptacle or above the toilet and plate. This area profrom the ceiling. The large for the opening noticeable rim on all This rim was large of around the protrudit be easily accessed.	During the tour, the com in room 208. A opening located on a sink was covered wortuded approximate the metal cover plate g it was covering, could side to support as a garea for a ligature by an individual star	e surveyor in old the ceiling ith a metal ly 2 inches was too eating a ding area. In item tied and could					
322-120.7 MAINTE	NANCE P&P	.	∟815	·			
The licensee shall: current, written police	(7) implement cies, procedures,	nt.					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From Pa contractors provide the committee did r prior to allowing the 322-120.1 SAFE EI WAC 246-322-120 The licensee shall: and clean environm staff and visitors; This RULE: is not r . Based on observatia a safe environment . Failure to provide a patients at risk of in Findings: On 1/18/2017 at 9:0 a tour of the facility, inspected the bathro outlet receptacle or above the toilet and plate. This area pro from the ceiling. The large for the openin noticeable rim on at This rim was large of around the protrudi be easily accessed the bathroom fixture 322-120.7 MAINTE WAC 246-322-120 The licensee shall: current, written police	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL Continued From Page 17 Contractors provide their own products at the committee did not perform a thoroug prior to allowing their use in patient care 322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: is not met as evidenced by Based on observation, the facility failed a safe environment for patients. Failure to provide a safe environment pl patients at risk of injury or death. Findings: On 1/18/2017 at 9:00 AM, Surveyor #1 of a tour of the facility. During the tour, the inspected the bathroom in room 208. A outlet receptacle or opening located on above the toilet and sink was covered we plate. This area protruded approximate from the ceiling. The metal cover plate large for the opening It was covering, or noticeable rim on all sides of the protruct This rim was large enough to support at around the protructing area for a ligature be easily accessed by an individual star the bathroom fixtures.	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From Page 17 contractors provide their own products and that the committee did not perform a thorough review prior to allowing their use in patient care areas. 322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors, This RULE: is not met as evidenced by: Based on observation, the facility failed to provide a safe environment for patients. Failure to provide a safe environment places patients at risk of injury or death. Findings: On 1/18/2017 at 9:00 AM, Surveyor #1 conducted a tour of the facility. During the tour, the surveyor inspected the bathroom in room 208. An old outlet receptacle or opening located on the ceiling above the toilet and sink was covered with a meta plate. This area protruded approximately 2 inches from the ceiling. The metal cover plate was too large for the opening it was covering, creating a noticeable rim on all sides of the protruding area. This rim was large enough to support an item tied around the protruding area for a ligature and could be easily accessed by an individual standing on the bathroom fixtures. 322-120.7 MAINTENANCE P&P WAC 246-322-120 Physical Environment. The licensee shall: (7) Implement current, written policies, procedures,	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From Page 17 Contractors provide their own products and that the committee did not perform a thorough review prior to allowing their use in patient care areas. 322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: is not met as evidenced by: Based on observation, the facility failed to provide a safe environment for patients. Failure to provide a safe environment places patients at risk of injury or death. Findings: On 1/18/2017 at 9:00 AM, Surveyor #1 conducted a tour of the facility. During the tour, the surveyor inspected the bathroom in room 208. An old outlet receptacle or opening located on the ceiling above the toilet and sink was covered with a meta plate. This area protruded approximately 2 inches from the ceiling. The metal cover plate was too large for the opening it was covering, creating a noticeable rim on all sides of the protruding area. This rim was large enough to support an item tied around the protruding area for a ligature and could be easily accessed by an individual standing on the bathroom fixtures. 322-120.7 MAINTENANCE P&P WAC 246-322-120 Physical Environment. The licensee shall: (7) Implement current, written policies, procedures,	DENTIFICATION NUMBER: A. BUILDING B. WING	FOORECTION Settle Settle	

STATE FORM

HZP911

If continuation sheet 18 of 27

STATEMENT AND PLAN O	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
L	504009			B. WNG		01/2	0/2017	
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>	STREET ADD	DRESS, CITY,	STATE, ZIP CODE			
NAVOS				THWEST H				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
L 815	Continued From Pa	ge 18	1	L 815		-	_	
	housekeeping funct This RULE: is not r	ions; net as evidenced by	:		_	•		
		on, the hospital faile embers properly perf ions.						
		erform housekeepin ff and patients at ris						
·		Committee (HICPAC nmendations - Environg g and Disinfecting SI urfaces in Patient-Co ce cleaning method	endations Control). 2004. onmental trategies are Areas. s that		·			
	Findings:		ļ					
	observed a daily cle third floor. Two hou #6) sprayed disinfed the surfaces of the which is a large-surf same cleaning proc	9:38 AM, Surveyor # aning of a patient ro sekeepers (Staff Me ctant from a spray be room, bathroom, and face cleaning metho edure was observed aning on the third flo	om on the imbers #4, ottle onto I furniture, d. This I during a		·			
	observed a discharge on the third floor. A #6) placed a mattrebed frame. S/he the to the recently clear	12:50 PM, Surveyor ge cleaning of a pation housekeeper (Staff as on the floor and clean returned the dirty ned bed frame in ording dirty items onto re	ent room Member leaned the mattress er to clean					

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If continuation sheet 19 of 27

STATEMENT AND PLAN O	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE S COMPL			
		504009		B, WING_		01/20	0/2017		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE	•			
NAVOS				DUTHWEST HOLDEN E, WA 98126					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX • TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	(X5) COMPLETE DATE			
L815	Continued From Pa	ige 19		L 815			_		
. ,	cleaned items has the potential to reintroduce contaminants to the cleaned items.				·				
L 985	322-150.3B EXAM	ROOM-LIGHT		L 985					
	Based on observation provide an examination on the second examination room pauboptimal care. Findings: On 1/18/2017 at 2:0	provide: (3) One amination rooms, exterior window, examination net as evidenced by the hospital failed tion light in the examination light in examination light in	d to nination n the c from						
	facility. No examina	ation light was presen er (CNO) (Staff Mem	nt. The						
L1145	322-180.1C RESTR	RAINT OBSERVATIO	NS	L1145			1		
	WAC 246-322-180 Seclusion Care. (1) shall assure seclusi are used only to the duration necessary safety of patients, s property, as follows observe any patient seclusion at least e) The licensee ion and restraint extent and to ensure the taff, and : (c) Staff shall in restraint or							

STATE FORM 021199 HZP911 If continuation sheet 20 of 27

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI.IA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	504009			B. WING _	 _	01/20/2017	
NAME OF F	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
NAVOS			2600 SOUT SEATTLE, '		OLDEN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE	
L1145				L1145		,	
	minutes, intervening as necessary, and recording observations and interventions in the clinical record; This RULE: Is not met as evidenced by:				·		
	Based on observation, interview and review of medical records, the hospital failed to provide evidence that staff monitored patients in seclusion and restraints according to hospital policy for 4 of 4 patients reviewed (Patient #2, #3, #4, and #7.)				•	•	
	Failure to do so placinjury or other declin	ces these patients at ne in status.	risk of	İ			
	Findings:			.			·
	Restraint", (Policy # in part: "C.4moni	by titled "Seclusion a 3024739, Rev. 4/201 tor the patient in sec t and document per	l6) states lusion or				
		edical records of 4 p led revealed the follo			·		
·	seclusion and 4-poi: 09:45 AM. The S/R document observati There was no docur indicate the staff me	rd indicated s/he was nt restraints on 12/7/flow sheet directed sions at 15 mlnute interested in the resembers completed por PM, 2:30 PM or 10:1tal 's policy.	2016 at staff to ervals. ard to attent			1	
	S/R on 10/3/2016 at directed staff to doo minute intervals. Th the record to indicate	rd indicated s/he was t 1:00 PM. The S/R sument observations here was no docume te the staff members nonitoring at 2:00 PM	flow sheet at 15 ntation in A, as				

If deficiencies are cited, an approved plan of correction is requisite to continued program participation

STATE FORM 921199 HZP911 If continuation sheet 21 of 27

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
}	.	504009		B. WING_	B. WING 01/2		0/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS. CITY. S	STATE, ZIP CODE			
NAVos				THWEST H	•			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL [ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE	
L1145	Continued From Pa	ge 21		L1145				
	outlined in the hosp	ital's policy.						
		ord indicated s/he was at 10:45 AM. The s		.				
		to document observ						
	15 minute intervals.	There was no docu	mentation					
		cate the staff membe		.			1	
•	completed patient n outlined in the hosp	nonitoring at 12:30 P	'M, as					
	Counted in the nosp	ital a policy.						
J		rd indicated s/he was		J]	
		7:30 AM. The S/R fl		ļ				
		ument observations ere was no docume			•			
		te the staff members						
ľ	completed patient m	nonitoring at 8:30 AN	1, on	ľ			<u> </u>	
		M and on 8/10/2019			•			
	AM, 9:15 AM, and 9 hospital's policy.	:30 AM, as outlined	in the					
	e. The Charge Nurs confirmed the above	se, (Staff Member #2 e findings.)					
L1150	322-180.1D PHYSI	CIAN AUTHORIZAT	ION .	L1150				
	WAC 246-322-180	Patient Safety and	.					
	Seclusion Care. (1)) The licensee	ļ					
	shall assure seclusi		Ī				}	
	are used only to the duration necessary							
	safety of patients, s							
	property, as follows	: (d) Staff shall						
İ	notify, and receive a				•	•		
	a physician within o initiating patient res			Į	· ·			
`	seclusion;							
 		met as evidenced by	:	:				
	Based on record re	view and review of h	ospital					
-		res, the hospital faile			E			
If deficiencie	s are cited, an approved	plan of correction is requi	site to continue	ed program p	articipation.		<u> </u>	

STATE FORM

If continuation sheet 22 of 27

HZP911

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1'''	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		504009		B. WING 01/20/2			0/2017	
NAME OF P	ROVIDER OR SUPPLIER		2600 SOU	DRESS, CITY, THWEST H WA 98126				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	(X5) COMPLETE DATE		
L1150	Continued From Pa	ge 22		L1150				
•	the earliest possible reviewed (Patient #: Failure to release parestraint at the earlie patients at risk for lof freedom. Findings: 1. The hospital policing Restraint " (Policy # in part: "Seclusion earliests.")	atients from seclusion est possible time plates of dignity and persy titled "Seclusion (13024739, Rev. 4/20 and Restraint shall be	on and ces rsonal and 16), states e used			· .		
	only to protect paties others, and only after have been attempte Seclusion and restrathe earliest possible 2. On 1/19/2017 bet Surveyor #2 reviewe	nts from harm to selier less restrictive alte d and found to be in alnt shall be disconti	f and ernatives effective. nued at 5:00 PM, nts that					
	a. On 12/7/2016 at 1 placed in restraints assault on another pin restraints until 8:4 states "in locked se Patient behavior wa	10:00 AM, Patient #2 at 10:00 AM followin batient. The patient r IS PM when the chat eclusion" [a form of n s noted as "Quiet" ent had not been rele O PM.	g an emained rt note estraint]. on the S/R					
-	placed in restraints staff during manual restraint and seclus the S/R Flow sheet removed", no further	6:14 PM, Patient #7 for an attempt to assessort of the patient ion room at 5:45 PM notes "remaining representation remained in least terms.	sault the to the l. At 7:15 straints d to harm		·	· .		

STATE FORM 621169 HZP911 If continuation sheet 23 of 27

) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY ETED
		504009		B. WING _		01/2	0/2017
NAME OF P	ROVIDER OR SUPPLIER			THWEST H	STATE, ZIP CODE OLDEN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
L1150	Continued From Page 23 seclusion [a form of restraint] until release at 9:45 PM.			L1150 _	•		
L1155	Based on record repolicles and procedensure staff obtained seclusion in 2 of 5 mand #7). Failure to obtain phyrestrictive seclusion of dignity, personal patient rights. Findings: 1. The hospital police Restraint" (Policy # in part: "Seclusion only to protect patie others, and only after have been attempted.	Patient Safety and The licensee on and restraint extent and to ensure the taff, and (e) A physician restrained or d renew the order r continuous hours usion; net as evidenced by view and review of h ures, the hospital fai d an order for locke ecords reviewed, (Pa ysician orders for a r places patients at ri freedom and violation cy titled "Seclusion a 13024739, Rev. 4/20 and Restraint shall be ents from harm to se er less restrictive alte and found to be in caint shall be discont	ospital led to d atient #2 new isk for loss on of and 16), states be used if and ernatives neffective.	L1155			
					<u> </u>		<u></u>

STATE FORM HZP911 If continuation sheet 24 of 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
•		,		A, BUILDING			
504009					B. WING 01/20/2017		
	PROVIDER OR SUPPLIER			DRESS, CITY, STATE, ZIP CODE			
NAVOS			2600 SOUT SEATTLE, V		OLDEN		. 1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETE DATE	
L1155	Continued From Page 24			 L1155			
	2. On 1/19/2017 between 10:00 AM and 5:00 PM, Surveyor #2 reviewed 5 patient records that had been placed in seclusion or restraints (S/R) and the following was noted: a. On 12/7/2016 at 10:00 AM, Patient #2 was placed in restraints following an assault to another patient. The patient was in restraints at 10:00 AM and released from restraints at 8:45 PM. The documented behavior on the flow sheet was described as "Quiet" after 6:45 PM and no further behavior is noted to justify the patient being placed in "locked seclusion" [a form of restraint] from 8:45 PM to 10:00 PM. There was no evidence in the chart of a physicians' order placing the patient in locked seclusion. b. On 8/10/2016 at 6:14 PM, Patient #7 was placed in restraints for attempt to assault a						
	hospital staff membershe patient to the S/I in restraints from 5:4 documented behavior described as "Quiet further behavior is no placed in "locked soft from 7:15 PM to 10: evidence in the characteristics."	er during the manual R room. The patient 45 PM until 7:15 PM or on the S/R flow start after 6:45 PM and oted to justify the patient of a physicians to on the locked seclusion the locked seclusion.	l escort of remained The neet was I no tient being restraint] order			·	,
L1220	322-200.1A RECOR	RDS-MANAGEMENT	r ,	L1220	· .		·
	WAC 246-322-200 (The licensee shall emaintain an organiz service, consistent principles of record directed, staffed, and (a) Ensure timely, caccurate identification	ed clinical record with recognized management, id equipped to: omplete and					

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATE FORM

#ZP911

#Continuation sheet 25 of 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
504009				B. WING_	B. WING		01/20/2017	
NAVOS 2600 SOL			DDRESS, CITY, STATE, ZIP CODE UTHWEST HOLDEN E, WA 98126					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE		
L1220	Based on interview falled to develop an medical records we	g, filing, and met as evidenced by and record review, to effective process to re accurate, complete ated by 4 medical re-	he hospital ensure te, and	L1220				
	and complete risks medical errors and princings:	edical records are ac omissions in patient potential for patient h al records revealed to	care, narm.	·				
	states in part: "Part	licy #3024739, Rev. ?. E. Patients will be milieu as soon as the Charge Nurse/ traine	4/2016) e ney are		•			
	S/R room for " aggi and assaultive beha face sheet. The Pat time of release was indicates observatio "quiet" between 1:1 no chart notes indic	1:00 PM, Patient #3 ressive, hostile, threativior as noted on the ient debriefing form: 2:00 pm. The S/R for of the patients' be 5 PM and 2:00 PM; ating a trained RN, the patient was clinicated the milieu.	atening face to states the flow sheet ehavior as there are Charge RN		•			
	point restraints for hidisorganized behavi	10:45 AM, Patient # nostile, agitated, para ior. The flow sheet ir s and the above beh	anoid and ndicates avior				,	

STATE FORM 021162 HZP911 If continuation sheat 28 of 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	504009			B. WING		01/20	01/20/2017	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ALL				STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·		
NAVOS	<u> </u>			THWEST H				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
L1220	12:00 and 12:15 ch released from all re are no chart notes i RN or LIP determin	age 26 AM, 11:15 AM, 11:30 lecks when the patie estraints and seclusic indicating a trained Fied the patient was crated into the milieu.	nt was on There RN, Charge	L1220	•			
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